

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/14/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/21/2011	
NAME OF PROVIDER OR SUPPLIER ST ANTHONY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DRIVE CROWN POINT, IN46307			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000				F0000	<p>St. Anthony Home ("the provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and / or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS"), the state of Indiana or any other entity; or (2) to serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 05/02/11.</p> <p>Survey dates: June 17, 20, and 21, 2011</p> <p>Facility number: 000120 Provider number: 155214 AIM number: 100274780</p> <p>Survey team: Regina Sanders, RN, TC Kelly Sizemore, RN</p> <p>Census bed type: SNF: 23 NF: 108 SNF/NF: 30 NCC: 12 Total: 173</p> <p>Census Payor type: Medicare: 24 Medicaid: 101 Other: 48 Total: 173</p> <p>Sample: 15</p> <p>These Deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 6/23/11</p>			F0000	<p>St. Anthony Home ("the provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and / or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS"), the state of Indiana or any other entity; or (2) to serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.</p>		

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F0282 SS=E	<p>Cathy Emswiller RN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p>			F0282	<p>F282</p> <p>1.1 Regarding resident #167, Unit Nurse Manager / designee immediately assessed resident on 6/20/11 with no adverse reactions noted. Licensed staff notified physician and family of the occurrence on 6/20/11.</p> <p>1.2 Unit Nurse Managers / designees completed rounds on 6/20/11 for all residents currently on oxygen to ensure the flow rate was accurate with no other deficiencies noted. Unit Nurse Managers / designees completed rounds on 6/20/11 for all residents currently receiving Enteral feedings to ensure proper infusion times were followed with no other deficiencies noted.</p>		07/15/2011

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					1.3 A directed inservice will be held for licensed staff regarding following physician orders related to proper administration of oxygen by 7/15/11. Licensed staff orientation program will be updated to reflect inservice content to ensure ongoing sustainable compliance. To monitor staff compliance with directed inservice training (and to allow management to immediately address potential noncompliance), Unit Nurse Managers / designees will complete rounds twice weekly of five (5) residents per unit on all shifts who require oxygen for six (6) months to ensure physician orders are being followed and flow rate is accurate beginning the week of 7/4/11. A directed inservice will be held for licensed staff regarding following physician orders related to proper administration of Enteral feedings by 7/15/11. Licensed staff orientation program will be updated to reflect inservice content to ensure ongoing sustainable compliance. To monitor staff compliance with directed inservice training (and to allow management to immediately address potential noncompliance), Dietitian / designee will complete rounds twice weekly of five (5) residents per unit on all shifts who require Enteral feedings for six (6) months to ensure proper infusion times are being followed		

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					beginning the week of 7/4/11. 1.4 The DON / designee will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 7/15/11. 2.1 Regarding resident #135, Unit Nurse Manager / designee immediately assessed resident on 6/20/11 with no adverse reactions noted. Licensed nurse notified physician and family of the occurrence on 6/20/11. 2.2 Unit Nurse Managers / designees reviewed current physician orders and MARs of residents receiving weekly blood pressures on 6/20/11 to ensure physician orders followed with no other deficiencies noted. 2.3 A directed inservice will be held for licensed staff regarding following physician orders related to obtaining weekly blood pressures by 7/15/11. Licensed staff orientation program will be updated to reflect inservice content to ensure ongoing sustainable compliance. To monitor staff compliance with directed inservice training (and to allow management to immediately address potential noncompliance), Unit Nurse Managers / designees will		

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					<p>complete audits twice weekly of five (5) residents per unit who require weekly blood pressures for six (6) months to ensure physician orders are being followed (reviewing current physician orders and MARs for accuracy / completion) beginning the week of 7/4/11.</p> <p>2.4 See 1.4 above.</p> <p>2.5 See 1.5 above.</p> <p>3.1 Regarding resident #145, Unit Nurse Manager / designee immediately assessed resident on 6/20/11 with no adverse reactions noted. Licensed staff notified physician and family of the occurrence on 6/20/11.</p> <p>3.2 Unit Nurse Managers / designees reviewed current physician orders, MARs and TARs of resident receiving eye drops on 6/20/11 to ensure physician orders followed with no other deficiencies noted. ADON notified pharmacy to ensure all medications will be documented on the MAR rather than TAR on 6/20/11.</p> <p>3.3 A directed inservice will be held for licensed staff regarding following physician orders related to eye drop administration by 7/15/11. Licensed staff orientation program will be updated to reflect inservice content to ensure ongoing sustainable compliance. To monitor staff compliance with directed inservice training (and to allow management to</p>		

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					<p>immediately address potential noncompliance), ADON / designee will review five (5) resident physician order sheets, MARs and TARs with eye drops twice weekly per unit for six (6) months to ensure physician orders are being followed (reviewing for accuracy / completion) beginning the week of 7/4/11.</p> <p>3.4 See 1.4 above.</p> <p>3.5 See 1.5 above.</p> <p>4.1 Regarding resident #33, licensed staff immediately assessed resident on 6/20/11 with no adverse reactions noted. Licensed staff notified physician and family of the occurrence on 6/20/11.</p> <p>4.2 Unit Nurse Managers / designees reviewed current physician orders and diabetic flow sheets of residents receiving blood glucose monitoring and insulin administration on 6/20/11 to ensure physician orders followed with no other deficiencies noted.</p> <p>4.3 A directed inservice will be held for licensed staff regarding following physician orders related to blood glucose monitoring and insulin administration by 7/15/11. Licensed staff orientation program will be updated to reflect inservice content to ensure ongoing sustainable compliance. To monitor staff compliance with directed inservice training (and to allow management to</p>		

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					<p>immediately address potential noncompliance), Unit Nurse Managers / designees will review five (5) resident POS and diabetic flow sheets per unit of those who receive blood glucose monitoring and insulin administration twice weekly for six (6) months to ensure physician orders are being followed (reviewing for accuracy / completion) beginning the week of 7/4/11.</p> <p>4.4 See 1.4 above.</p> <p>4.5 See 1.5 above.</p> <p>5.1 Regarding resident #24, licensed staff immediately assessed resident on 6/20/11 with no adverse reactions noted. Licensed staff notified physician and family of the occurrence on 6/20/11.</p> <p>5.2 Unit Nurse Managers / designees reviewed current physician orders and MARs of residents receiving antiplatelet medication on 6/20/11 to ensure physician orders followed with no other deficiencies noted.</p> <p>5.3 A directed inservice will be held for licensed staff regarding following physician orders related to antiplatelet medication administration by 7/15/11. Licensed staff orientation program will be updated to reflect inservice content to ensure ongoing sustainable compliance. To monitor staff compliance with directed inservice training (and to allow management to immediately address potential</p>		

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	<p>Based on observation, record review, and interview, the facility failed to ensure physicians' orders and care plans were followed, related to, oxygen, tube feeding times, a blood pressure, and medications, for 5 of 15 residents reviewed for physicians' orders and care plans in a sample of 15. (Residents #24, #33, #135, #145, and #167)</p> <p>Findings include:</p> <p>1. During an observation of Resident #167 on 06/20/11 at 8:30 a.m., the resident was in her room and the tube feeding was infusing at 60 cc (cubic centimeters) an hour and the resident's oxygen was being administered by nasal canula at 7 liters per minute.</p> <p>During an observation of the resident on 06/20/11 at 8:50 a.m., with RN Unit Manager #5 present, the resident was in her room. During interview at that time,</p>				<p>noncompliance), Unit Nurse Managers / designees will complete audits twice weekly of five (5) residents per unit who require antiplatelet medication for six (6) months to ensure physician order followed (reviewing for accuracy / completion) beginning the week of 7/4/11.</p> <p>5.4 See 1.4 above.</p> <p>5.5 See 1.5 above.</p>		

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	<p>the RN Unit Manager indicated the resident's tube feeding was still infusing at 60 cc an hour and she indicated the resident's oxygen was set at 8 liters per minute.</p> <p>Resident #167's record was reviewed on 06/20/11 at 8:35 a.m. The resident's diagnoses included, but were not limited to respiratory failure and hypertension.</p> <p>A care plan, dated 06/16/11, indicated the resident had a tube feeding present. The interventions included, "...Provide feeding via pump per MD orders..."</p> <p>A care plan, dated 06/16/11, indicated the resident required supplemental oxygen. The interventions included, "...O2 (oxygen) per md (sic) orders..."</p> <p>A physician's order, dated 06/16/11, indicated the resident's tube feeding was to be increased on 06/18/11 to 60 cc's an hour for 16 hours, on at 3 p.m. and off at 7 a.m.</p> <p>The resident's medication record, dated 06/11, indicated the tube feeding was started on 06/19/11 at 3 p.m.</p> <p>A physician's order, dated 06/19/11 indicated an order for oxygen at 10 liters per minute.</p>						

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	<p>2. Resident #135's record was reviewed on 06/20/11 at 11 a.m. The resident's diagnoses included, but were not limited to, hypertension and gout.</p> <p>The Physician's Recapitulation Orders, dated 06/11, indicated an order to monitor the resident's blood pressure weekly on Fridays.</p> <p>The Medication Administration Record, dated 06/11, indicated the resident's blood pressure had been monitored on 06/03/11. There was a lack of documentation to indicate the resident's blood pressure had been monitored on 06/10/11 and 06/17/11 (Fridays).</p> <p>A Nurses' Note, dated 06/13/11 at 6:01 p.m., indicated the resident's blood pressure was 116/74. The Nurses' Notes dated 06/10/11 through 06/20/11 at 4:18 a.m., lacked documentation to indicate the resident's blood pressure had been monitored as ordered by the resident's physician.</p> <p>During an interview on 06/20/11 at 11:15 a.m., LPN #2 indicated she did not find documentation to indicate the resident's blood pressure had been monitored as ordered by the physician.</p>						

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	<p>3. Resident #145's record was reviewed on 06/20/11 at 10:30 a.m. The resident's diagnoses included, but were not limited to, hypertension and diabetes mellitus.</p> <p>The Physician's Recapitulation orders, dated 06/11, indicated an order for artificial tears, administer two drops into both eyes three times daily. The order was originated on 03/25/11.</p> <p>The resident's treatment record, dated 06/11, indicated the medication had not been administered as ordered. There was a yellow highlighted line through the order and no initials were on the treatment record to indicate the eye drops had been given.</p> <p>The Medication Administration Record (MAR), dated 06/11, lacked documentation to indicate the artificial tears had been administered as ordered by the physician and lacked documentation the resident had an order for the artificial tears.</p> <p>The physician's orders, from 03/25/11 to 06/20/11, lacked documentation to indicate the artificial tears had been discontinued.</p> <p>During an interview on 06/20/11 at 10:55 a.m., LPN Unit Manager #1 indicated she</p>						

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	<p>could not find where the artificial tears had been administered as ordered by the physician. She indicated there had not been a discontinuation order written for the artificial tears.</p> <p>4. Resident #33's record was reviewed on 6/20/11 at 11:15 a.m. Resident #33's diagnoses included, but were not limited to, insulin dependent diabetes mellitus, hypertension, and dementia.</p> <p>A Physician's Recapitulation Orders, dated 06/11 with an original date of 1/21/11, indicated blood glucose monitoring check and record 2 times daily at 6 a.m. and 4 p.m. and an order for Insulin Novolin R per sliding scale (insulin given based on blood sugar results): sub-Q (subcutaneous):</p> <p>60-150= 0 units 151-200= 2 units 201-250= 4 units 251-300= 6 units 301-350= 8 units 351-400= 10 units > (over) 400= 12 units < (less than) 60 or >400 Call MD</p> <p>A Diabetes Care Plan, dated 11/8/10 and updated 5/11, indicated "...Accuchecks as ordered. Administer insulin per sliding scale..."</p>						

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	<p>A Diabetic Flow Sheet, dated 06/2011, indicated on 6/16 at 4 p.m. the resident's blood sugar was 161 and no insulin was given.</p> <p>During an interview with LPN #6, on 6/20/11 at 2:05 p.m., she indicated 2 units of insulin should have been given.</p> <p>5. Resident #24's record was reviewed on 6/20/11 at 8:55 a.m. Resident #24's diagnoses included, but were not limited to, congestive heart failure, left above knee amputation, and atrial fibrillation.</p> <p>A Physician's Recapitulation Order, dated 06/11 with an original date of 9/10/09, indicated Anagrelide HCL (antiplatelet medication) 0.5 milligrams 1 capsule by mouth daily, hold if platelets <250 notify N/P (Nurse Practitioner).</p> <p>Lab results for platelets, dated 6/17/11, indicated a result of 418 (normal values 130-400). At the bottom of the lab it was indicated to "restart agrelide (sic)."</p> <p>A Medication Administration Record (MAR), dated 06/2011, indicated Anagrelide HCL 0.5 milligrams 1 capsule by mouth daily, hold if platelets <250 notify N/P (Nurse Practitioner). The dates 6/17-6/20 were initialed and circled, which indicated the medication had not</p>						

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	been given. During an interview with LPN #6, on 6/20/11 at 10:35 a.m., she indicated the medication was not in the medication strip. The order was not written so pharmacy did not send it, so it was not given. This Federal tag was cited on 05/02/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-35(g)(2)						

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F0441 SS=D	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>			F0441	F441 1.1 Regarding resident 167, wound was assessed by Unit Nurse Manager with no signs and symptoms of infection noted on 6/20/11.		07/15/2011

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					1.2 Unit Nurse Managers / designees assessed residents with wounds that require a dressing change for signs and symptoms of infection by 6/23/11 with no deficiencies noted. 1.3 A directed inservice will be held for licensed staff regarding infection control protocols, hand-washing and isolation practices during dressing changes by 7/15/11. Licensed staff orientation program will be updated to reflect inservice content to ensure ongoing sustainable compliance. To monitor staff compliance with directed inservice training (and to allow management to immediately address potential noncompliance), Director of Staff Development / designee will conduct four (4) random supervised dressing changes weekly for six (6) months with different licensed staff (reviewing for compliance with protocols) beginning the week of 7/4/11. 1.4 The DON / designee will report audit findings to the Continuous Quality Improvement (CQI) Committee monthly for six (6) months. The CQI Committee will monitor data presented for any trends, and determine if further monitoring is necessary for compliance. 1.5 Systemic changes will be completed by 7/15/11. 2.1 Regarding resident #24, wound was assessed by Unit		

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	<p>Based on observation, record review, and interview, the facility failed to ensure infection control protocols were practiced by licensed staff related to handwashing and isolation practices during dressing changes for 2 dressing changes observed for 2 of 5 resident's with dressing changes in a sample of 15. (Residents #24 and #167, LPN #3, LPN #7, and RN #4)</p> <p>Findings include:</p> <p>1. During an observation of a dressing change of Resident #167's dressing on her sacrum, on 06/20/11 at 12 p.m., with LPN #3 and RN #4 the following was observed:</p> <p>LPN #3 and RN #4 washed their hands and applied gloves. RN #4 assisted the resident to turn on her left side. LPN #3 removed the resident's dressing from the sacral area. LPN #3 then removed her gloves and applied a new pair of gloves without washing her hands. LPN #3 then washed the sacral wound with a gauze and normal saline. LPN #3 then removed her gloves and applied a new pair of gloves</p>				<p>Nurse Manager with no signs and symptoms of infection noted on 6/21/11.</p> <p>2.2 See 1.2 above.</p> <p>2.3 See 1.3 above.</p> <p>2.4 See 1.4 above.</p> <p>2.5 See 1.5 above.</p>		

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	<p>without washing her hands. LPN #3 then used a cotton tipped swab to apply Santyl (debridement ointment) to the sacral area. LPN #3 then removed her gloves and applied new gloves, without washing her hands and applied a lightly moistened dressing to the wound. LPN #3 then removed her gloves and applied new gloves, without washing her hands, dated the dressing then removed her gloves and applied new gloves, without washing her hands. LPN #3 then applied an ointment to the resident's groin area with a wooden tongue depressor. LPN #3 then fastened the resident's brief, took her gloves off and applied new gloves, without washing her hands. LPN #3 then placed the charge stickers for the supplies on the charge slip located on the bathroom door, then removed her gloves and washed her hands.</p> <p>During an interview on 06/20/11 at 12:15 p.m., LPN #3 indicated she was suppose to wash her hands between taking the old dressing off and the putting the new dressing on.</p> <p>A facility policy, dated 08/09, titled, "Dressing Changes-Wounds", identified as current by the Director of Nursing, indicated, "...5. Remove old dressings, remove gloves, and dispose of appropriately. 6. Wash hands. Put on</p>						

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	<p>gloves...9. Apply medications/dressings to wound...Remove gloves...11. Wash hands..."</p> <p>2. During the initial tour on 6/17/11 at 9:50 a.m. with LPN #6, she indicated the resident had a MRSA (methicillin resistant staphylococcus aureus) infection of the third digit of the right foot. There was an isolation cart outside of the resident's room in the hallway.</p> <p>Resident #24's record was reviewed on 6/20/11 at 8:55 a.m. Resident #24's diagnoses included, but were not limited to, congestive heart failure, left above knee amputation, and atrial fibrillation.</p> <p>A care plan, dated 06/06/11, indicated, "...Acute infection of MRSA to rt (right) foot 3rd dig. (digit), ...Maintain contact isolation..."</p> <p>A Culture report for right 3rd toe, dated 6/3/11, indicated "...Culture results many staphylococcus aureus (methicillin resistant)..."</p> <p>During an observation on 6/21/11 at 10:15 a.m., LPN #7 entered resident #24's room to do the resident's dressing changes. LPN #7 did not put on a gown to cover her uniform. LPN #7 washed her hands and put on gloves. She put a blanket on the floor and sat on the blanket to complete</p>						

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	<p>the dressing changes. She removed a sock that was soiled with betadine from the dressing on the right calf and put it on the floor. She removed the soiled dressing from the right calf, washed her hands, applied gloves and removed the right third toe dressing. There was a yellow substance on the third soiled toe dressing. LPN #7 completed the dressing changes and then stood up and the soiled sock touched LPN #7's pant leg.</p> <p>During an interview at the time of the observation with LPN #7, she indicated she should have wore a gown during the dressing change due to the resident being on contact isolation. She also indicated the soiled sock should not have been put on the floor. She indicated it should have been put in a bag.</p> <p>During an interview with LPN #6, on 6/21/11 at 10:37 a.m., she indicated the resident was still on contact isolation due to the MRSA in the right third toe. She indicated LPN #7 should not have put the soiled sock on the floor, she should have put it in a bag.</p> <p>A facility policy titled, "Transmission-Based Precautions Contact Precautions," dated 2/09 and revised 6/11, received as current from the Director of Nursing, indicated "...Policy...residents</p>						

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	<p>known...to be infected...with epidemiologically important microorganisms that can be transmitted by direct contact with the resident (hand or skin-to-skin contact that occurs when performing resident-care activities that require touching the resident's dry skin) or indirect contact (touching) environmental surfaces or resident-care items in the resident's environment...Procedure...GOWN...1...we ar a gown if you anticipate that clothing will have substantial contact with the resident, environmental surfaces, or items in the resident's room...LINENS...1. Handle, transport, and process used linen soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and avoids transfer of microorganisms to other residents, staff, and environment...3. Linens will be handled in a manner that prevents contact with the employee's clothing..."</p> <p>A Professional Resource, titled, "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007" from the CDC (Centers of Disease Control), page 70, indicated, "... III.B.1. Contact Precautions...The application of Contact Precautions for patients infected or</p>						

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	colonized with MDROs (multi drug-resistant organism)...Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment..."						
	This Federal tag was cited on 05/02/11. The facility failed to implement a systemic plan of correction to prevent recurrence.						
	3.1-18(j) 3.1-18(l)						

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